Minnesota Multistate Contracting Alliance for Pharmacy
Facility Membership Application

The completed form must be returned to the State Contact for authorization. The State Contact will then forward the authorized form to the MMCAP office for processing.

Type or print clearly.

1. *The statutory authority under which this facility may purchase goods from state contracts is:

   R.S. 39 : 1702 (give specific statutory citation).

2. *Which contracts will this facility use? Check all that apply.

   ✓ Pharmaceutical ____ Flu Vaccine _____ Hospital & Medical Supplies ____ ALL THREE

3. *Facility Name: _____

   *On-site purchasing contact person: _____

   *Title: _____ *Phone: _____ *Fax: _____

   *E-mail Address: _____

   *Street Address (include P.O. Box if applicable): _____

   *City: _____ *State: _____ *ZIP: _____

   *DEA number: _____ *HIN number: _____

   *Average purchases of pharmaceutical per month: $_____

4. Please check the phrase that best describes your facility:

☐ Correctional Facility	☐ Public/Community Health Department
☐ Mental Health Treatment Facility	☐ Oncology Center
☐ Acute Care Hospital	☐ Nursing Home
☐ Student Health Service	☐ Veterinary School
☐ Community Health Clinic Facility	☐ Other (describe) _____

   *Size of Facility: Beds _____ *Annual Clinic Visits _____ *Annual Rx's _____

The above information is true and correct.

Signed: _____ Date: _____

Barbara Rhodes, MMCAP LA State Contact
Tel: 225-342-8035 · E-mail: brhodes@doa.state.la.us

MMCAP Fax: 651-297-3996

Submit